GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 21, 2020

Brian Pangle
Clark Retirement Community Inc.
1551 Franklin SE
Grand Rapids, MI 49506

RE: License #: AL410238273
Investigation #: 2020A0355019
Windsor Manor South

Dear Mr. Pangle:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Grant Sutton, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4437

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AL410238273
Investigation #:	2020A0355019
Complaint Receipt Date:	12/05/2019
Investigation Initiation Date:	12/10/2019
Report Due Date:	02/03/2020
Licensee Name:	Clark Retirement Community Inc.
Licensee Address:	1551 Franklin SE Grand Rapids, MI 49506
Licensee Telephone #:	(616) 278-6543
Administrator:	Nancy Ayers
Licensee Designee:	Brian Pangle
Name of Facility:	Windsor Manor South
Facility Address:	2499 Forest Hill Avenue SE Kentwood, MI 49546-8257
Facility Telephone #:	(616) 278-6543
Original Issuance Date:	09/10/2002
License Status:	REGULAR
Effective Date:	03/10/2018
Expiration Date:	03/09/2020
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Staff would not communicate with family member #1, even though he was 2nd on the list as Resident A's Power of Attorney.	Yes
Resident A did not receive medication for pain in a timely manner.	No
Resident A may have received PRN medications for pain too close together.	No
Resident A was deprived of urgent medical care in a timely manner.	No
There is a question as to whether PRN medications for pain were documented in the medication record when passed to Resident A.	No
There is a question as to whether staff are properly trained.	No
Additional Findings	Yes

III. METHODOLOGY

12/05/2019	Special Investigation Intake 2020A0355019
12/10/2019	APS Referral
12/10/2019	Special Investigation Initiated - Telephone APS referral made
12/12/2019	Contact - Telephone call received Complainant
12/19/2019	Inspection Completed On-site Unannounced; interviewed administrator
12/19/2019	Contact - Telephone Call Received Complainant
01/06/2020	Contact - Telephone Call Made Ambulance provider
01/06/2020	Contact - Telephone Call Received Complainant
01/10/2020	Contact - Document Sent 30-day letter to complainant
01/14/2020	Contact - Face to Face

	Complainant
01/17/2020	Contact - Face to Face Interviewed staff; reviewed file materials for Resident A
01/17/2020	Contact - Telephone call received Complainant
01/21/2020	Contact - Telephone call received Message left by Kent Co. Prosecutor; status of complaint?
01/22/2020	Contact - Telephone call made Message left for Kent Co. Prosecutor
01/29/2020	Contact - Telephone call received Interviewed family member
01/31/2020	Contact - Face to face Reviewed charting for vitals; reviewed staff files
02/03/2020	Contact - Telephone call received Interviewed Resident A's physician
02/07/2020	Contact - Telephone call made Interviewed staff
02/11/2020	Contact - Telephone call made Interviewed staff
02/12/2020	Contact - Telephone call made Interviewed staff x 2
02/19/2020	Contact - Telephone call received Complainant
02/20/2020	Exit Conference Licensee designee

ALLEGATION: Staff would not communicate with family member #1, even though he was 2nd on the list as Resident A's Power of Attorney.

INVESTIGATION: On 12/05/2019, the Department received a complaint alleging that the facility staff would not communicate information regarding Resident A to

family member #1 even though he is listed as 2nd Durable Power of Attorney (DPOA) for Resident A.

On 12/12/2019, I received a telephone call from FM#1 expressing frustration with the fact that especially following the death of Resident A, the facility staff would not share information regarding Resident A or answer questions about her health and events prior to her death, even though FM#1 was the back-up power of attorney. This led FM#1 to be concerned that the licensee was "hiding" information from Resident A's family. FM#1 stated that he began to feel the licensee was potentially "covering up" some malfeasance committed by the licensee with Resident A. FM#1 stated that his calls to staff and the administrator following Resident A's death were met with; "I will call you back" but the calls were not returned. FM#1 stated that he did not call the licensee back after staff did not return his calls.

On 01/17/2020, I reviewed on-site the concern expressed by FM#1 with the administrator, Nancy Ayers. Ms. Ayers stated that since FM#1 was listed as 2nd on the list for the DPOA, the licensee felt they were honoring the spirit of the DPOA documents by only discussing Resident A's case with FM#1 when FM#2, who was listed as the first contact, was truly not available. Ms. Ayers stated that while the licensee wanted to support FM#1 and his questions & concerns, the telephone calls from FM#1 to staff on the unit could feel confrontational to staff and interfere with their work. Ms. Ayers stated that staff were never told specifically they couldn't talk to FM#1 but staff were directed to follow the DPOA and talk to FM#1 only when FM#2 was not available. Ms. Ayers did not have a response to FM#1's concerns that his calls after Resident A died were not returned, pointing out that it has been over a year.

On 01/17/2020, I reviewed Resident A's facility file. The 'face sheet' for the file indicates that FM#2 is the first contact in case of emergency, FM#1 was listed as the second contact, and FM#3 was listed as the third contact if neither FM#2 or FM#1 were available.

On 02/12/2020, I interviewed by telephone staff Rejema Griffin. Ms. Griffin stated that during the early hours of 01/08/2019, she attempted to contact by telephone FM#2, who is listed first on the DPOA list. Ms. Griffin stated that FM#1 answered the phone and stated FM#2 was not available. Ms. Griffin asked for FM#2, believing she was supposed to talk to him. Ms. Griffin stated that she was interrupted by staff Aida Kubic to assist with Resident A and told FM#1 that she would call back. Ms. Griffin stated that FM#2 contacted the facility soon after but Ms. Griffin was in the midst of working with the ambulance personnel and couldn't talk so a staff from another building let FM#2 know that Resident was being sent to the hospital. Ms. Griffin reiterated the belief that if FM#2 was available, she was not supposed to talk to FM#1, per what was written in Resident A's chart.

On 02/19/2020, I reviewed with FM#1 the findings of my investigation.

On 02/20/2020, I completed an exit conference by telephone with the acting licensee designee, Nancy Ayers. The licensee provided a document designating Ms. Ayers as the licensee designee since Mr. Pangle is out of town for several weeks. Ms. Ayers accepted the findings of my investigation but wanted it noted that she disagrees with my conclusion.

APPLICABLE RULE	
R 400.15201	**Qualifications of administrator, direct care staff, licensee, and members of the household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food service staff.**
	(11) A licensee, direct care staff, and an administrator shall be willing to cooperate fully with a resident, the resident's family, a designated representative of the resident and the responsible agency.
ANALYSIS:	The administrator, Nancy Ayers, stated that staff were directed to follow the DPOA documents and talk to FM#2 as the first emergency contact. Ms. Ayers stated that staff were never told specifically they couldn't talk to FM#1 but staff were directed to follow the DPOA and talk to FM#1 only when FM#2 was not available. Staff Rejema Griffin stated she attempted to contact FM#2 as listed in DPOA document. Because FM#1 was identified and included as a contact person for Resident A, staff should have communicated with him when he requested information regarding Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A did not receive medication for pain in a timely manner.

INVESTIGATION: On 12/05/2019, the Department received a complaint alleging that on the evening of 01/07/2019, Resident A seemed to be in considerable "distress", quite possibly in "agony". Resident A passed away at Spectrum Butterworth Hospital on 01/08/2019.

On 12/19/2019, I conducted an unannounced investigation at the facility and interviewed the administrator, Nancy Ayers. At this time, I gave Ms. Ayers a list of documents/information that I needed to review from Resident A's facility file and on-line medical record.

On 01/14/2020, I interviewed FM#1 off-site. FM#1 stated that during a telephone call with Resident A on the evening of 01/07/2019 at about 7:15 p.m., FM#1 noted that Resident A repeatedly made a sound that communicated discomfort and was atypical for Resident A. FM#1 stated that Resident A was not forming words well which also suggested that she was in pain. FM#1 acknowledged that Resident A had issues with her memory and cognitive functioning but as stated, FM#1 noted that Resident A's communication was atypical during their telephone conversation on 01/07/2019. FM#1 recalled that FM#2 had called the facility at approximately 7:30 p.m. to ask that a PRN medication for pain be given to Resident A and spoke with staff Della Hunicutt who indicated that the medication passer was on break at that moment. When FM#1 called staff Melissa Melberg, who was the medication passer, at about 8:06 p.m. to see if Resident A had received the message from FM#*2's* earlier call, FM#1 was told only that Resident A had been, "put to bed." FM#1 stated that no additional information was provided as to whether or not Resident A received a PRN medication for pain.

On 01/17/2020, I met with the administrator, Nancy Ayers, and staff Tina Raimer at the facility and I reviewed Resident A's medication log for 01/07/2019 and Daily Charting logs, as well.

Ms. Ayers stated that staff Melissa Melberg was the medication passer for the evening of 01/07/2019. Ms. Ayers informed me that Ms. Melberg would not be available for an interview as she had passed away during 2019.

The medication log indicated that at 8:11 p.m., Resident A received Norco 5 mg-325 mg tablet by mouth for pain. The medication log indicated that at 10:40 p.m., Resident A received Morphine concentrate 100 mg/5 ml oral solution because of continued pain. In each instance, the PRN medication was documented as passed by Melissa Melberg. The medication log indicated that the 10:40 p.m. PRN was the last passed for the evening and no PRN medication was passed during the night of 01/08/2019. It was documented in the medication log that Resident A had also previously received a PRN medication for pain on 01/02/2019.

I reviewed the Daily Charting logs for 01/05 – 07/2019 which indicated that Resident A was checked by staff every two hours, every shift and every day. The checks occurred at 1:00 a.m., 3:00 a.m., 5:00 a.m., 7:00 a.m., 9:00 a.m., 11:00 a.m., 1:00 p.m., 3:00 p.m., 5:00 p.m., 7:00 p.m., 9:00 p.m., and 11:00 p.m. There were two 'Interdisciplinary Notes' completed by staff Rejema Griffin; one for 01/05/2019 in which she described that Resident A stated she was "in great pain on both of her legs" during the 3rd shift so a PRN medication for pain was administered. The second note was completed by Rejema Griffin on 01/08/2019 which described action taken by staff during the 3rd shift prior to sending Resident A to the hospital.

On 02/03/2020, I interviewed by telephone Dr. Neubig, the physician who regularly saw Resident A at the facility. Dr. Neubig stated that per discussions with FM#1,

she wrote orders for staff to pass the Norco first to Resident A for pain and then if Resident A was still in pain after an hour, they could pass Resident A the Morphine.

On 02/19/2020, I reviewed by telephone the outcome of my investigation with FM#1.

On 02/20/2020, I conducted by telephone an exit conference with the acting licensee designee, Nancy Ayers. Ms. Ayers concurred with the findings of my investigation.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.**
ANALYSIS:	During the evening of 01/07/2019, FM#1 identified that Resident A was in pain. FM#2 reported that he contacted the facility at approximately 7:30 p.m. to request that a PRN medication for pain be given. The medication log indicates that Resident A received a PRN of Norco for pain at 8:11 p.m. and a PRN of Morphine at 10:40 p.m. I do not find a preponderance of evidence to support that a rule violation has occurred.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A may have received PRN medications for pain too close together.

INVESTIGATION: On 12/05/2019, the Department received a complaint alleging that on the evening of 01/07/2019, Resident A received two PRN medications for pain, possibly given too close together.

On 01/17/2020, I reviewed materials from the medication record in Resident A's facility file from the evening of 01/07/2019. The medication record indicated that on 8:11 p.m., Resident A received a PRN of Norco 5 mg-325 mg tablet and the medication record indicated "diagnosis/reason = pain. The medication record indicated that at 10:40 p.m., Resident A received a PRN of Morphine concentrate 100 mg/5 ml oral solution. The medication record indicated that the Morphine could be used, "only after Norco fails to give relief in 1 hour", diagnosis/reason = pain only

after Norco. As stated previously, staff Melissa Melberg, now deceased, was the medication passer on 01/07/2019 during the 2nd shift.

On 02/03/2020, I interviewed by telephone Dr. Neubig, the physician who regularly saw Resident A at the facility. Dr. Neubig stated that per discussions with FM#1, she wrote orders for staff to pass the Norco first to Resident A for pain and then if Resident A was still in pain after an hour, they could pass Resident A the Morphine.

On 02/19/2020, I reviewed by telephone the findings of my investigation with FM#1.

On 02/20/2020, I completed by telephone an exit conference with the acting licensee designee, Nancy Ayers. Ms. Ayers concurred with the findings of my investigation.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.**
ANALYSIS:	The medication log for Resident A indicates that Resident A received a PRN of Norco for pain at 8:11 p.m. and a PRN of Morphine at 10:40 p.m. The medication log indicates that the Morphine may be given an hour after the Norco if the Norco does not provide adequate relief from pain. I do not find a preponderance of evidence to support that a rule violation has occurred.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A was deprived of urgent medical care in a timely manner.

INVESTIGATION: On 12/05/2019, the Department received a complaint alleging that during the night of 01/08/2019 (3rd shift), Resident A was deprived of urgent medical care in a timely manner.

On 12/05/2019, the Dept. received a complaint alleging that during the 3rd shift on 01/08/2019, vital signs obtained by staff indicated that Resident A had severe hypotension and tachycardia. Hypoxia was also reported. The complaint alleges

that despite unmistakable suffering and alarming vital signs, there was an inordinate delay before emergency medical care was sought.

On 01/06/2020, I contacted the company that dispatched the ambulance that transported Resident A to the hospital on 01/08/2019 to see if the EMT's could provide additional information possibly not included in the report they completed on 01/08/2019. The company would neither confirm nor deny if the two individuals listed in the report are currently employees.

On 01/14/2020, I met off-site with FM#1. FM#1 stated that FM#2 had visited Resident A late in the afternoon of 01/07/2019, and at that time, FM#2 reported to FM#1 that Resident A did not seem to be in discomfort. FM#1 also provided for my review a copy of the note completed by Atria Home Nursing Care indicating that Resident A was seen on 01/07/2019 and her vitals were within typical parameters for Resident A and her lungs were clear. FM#1 stated that during the night of 01/08/2019, facility staff contacted him and FM#2 by telephone and informed them that Resident A was being transported to the hospital due to observed hypotensive issues (repeated low blood pressure readings).

During this meeting, FM#1 provided me with a copy of the report completed by the EMT from Life EMS Ambulance. The report indicates that the 911 call was received at 5:31 a.m. and the ambulance arrived at 5:38 a.m. The report indicates that Resident A was in her room sitting in a chair when they encountered her, and Resident A did not appear to be in any respiratory distress. The report indicates that the Kentwood Fire Dept. was already on-site. When asked why 911 was called, the staff present stated that Resident A's blood pressure was 50/20 and Resident A was "not acting right." When asked how the BP was obtained, a BP machine was pointed to by staff. When asked what "not acting right" was, the staff responded, "this isn't my patient, I normally don't work in this wing." When asked who contacted 911, the staff indicated that 3rd shift staff called, and that person was not currently in this facility. The staff who contacted 911 was called and indicated to the EMT that Resident A had a "mouth droop that started around 5:00 a.m." When asked why 911 was not contacted then, the staff did not answer the EMT. When the EMTs got Resident A into the ambulance, Resident A was "slightly hypotensive" and did not appear to have any chest pain. The EMT completing the report listed what the heart monitor was telling him which he communicated to the Butterworth Hospital Emergency room doctor who gave the EMT instructions while on the way to the hospital. Resident A was taken to Butterworth Hospital where she was admitted to the Emergency Dept. for evaluation and treatment.

FM#1 provided for review a report generated by the Spectrum Butterworth Emergency Dept. upon Resident A's admission. Resident A was identified as being in Septic Shock in addition to her other diagnoses.

FM#1 stated that an order had previously been written by Resident A's physician for the facility to check her vital signs more frequently which were to be shared with

Resident A's cardiologist. FM#1 wondered if the facility had been following the order.

On 01/17/2020, I reviewed Resident A's facility file, including medication records. While on-site, the administrator, Nancy Ayers, and nursing staff, Tina Raimer, sat in to answer questions.

Ms. Ayers pointed out that the licensee was in the process of switching from a hand-written system of daily notes and documentation to an on-line system around the date of 01/07/2019. Ms. Ayers stated that if something out of the ordinary occurred during the shift, staff would complete an 'Interdisciplinary Note' that would be added to the daily charting.

Resident A's date of birth was 02/02/1925. Resident A's diagnoses included, chronic kidney disease, chronic back pain, chronic anemia, myocardial infarction, Bullous eruption (onset 11/15/2018, systolic dysfunction, arthritis, hypertensive disorder, peripheral arterial occlusive disease, hypothyroidism, coronary atherosclerosis, non-Hodgkin's lymphoma of nose, mitral valve regurgitation, hyperlipidemia, essential hypertension, and diabetes mellitus.

Included in the file is a note competed by Dr. Neubig when she saw Resident A at the facility on 01/02/2019 for lower limb ischemia. Dr. Neubig noted that this is most likely the cause of the severe pain Resident A was experiencing which resolves when Resident A's legs are lowered (as in sitting up in her chair). Dr. Neubig noted that when Resident A's legs are lowered, however, Resident A experiences increased edema or swelling in her lower legs which over time, increases "the risk of open areas" or ulcers on Resident A's legs which she had experienced before.

Present in the file was an order from Dr. Neubig for Resident A's vital signs to be checked once daily and faxed weekly to Resident A's cardiologist, Dr. Furman. The order was signed on 01/04/2019 and was to begin on 01/08/2019.

The medication log indicated that all of Resident A's medications were passed as prescribed, including blood sugar checks twice per day as prescribed and Novolog Flexpen administered when the blood sugar registered outside the parameters given by Resident A's physician. As described in earlier sections, Resident A received a PRN for pain at 8:11 p.m. and another at 10:40 p.m., each during the 2nd shift and each administered by staff Melissa Melberg on 01/07/2019.

The 'Daily Charting' for 01/07/2019 completed by 2nd shift staff Della Hunnicutt and staff Melissa Melberg indicated that Resident A was checked every two hours, per the licensee's policy. Resident A ate 75% of her dinner which did not appear out of the ordinary when I reviewed earlier Daily Charting sheets for meal intake. The Daily Charting for the 3rd shift completed by staff Hannah Smith and Aida Kudic indicated that Resident A was checked every two hours. Included in the charting for each shift was personal care provided to Resident A, including bowel movements.

An ‘Interdisciplinary Note’ was completed by staff Rejema for the 3rd shift on 01/08/2019 describing action taken by staff before sending Resident A to the hospital on an emergent basis. The time stamp from the computer for when this note was entered was 7:41 a.m. on 01/08/2019. The note included that Resident A had passed away at the hospital. The note stated that at approximately 4:00 a.m., Resident A was calling/crying for help so she was transferred from her bed to her recliner and, “though she wasn’t complaining of pain, (Resident A) was observed as sweating and her skin was cold to touch.” Staff took Resident A’s vitals at approximately 4:38 a.m. and her blood pressure was 70/44, pulse 140, temperature 95.9, respiration 22 and oxygen was 95%. At 4:43 a.m. vitals were taken, and Resident A’s blood pressure was 59/37, pulse 145, temperature at 95.5 and oxygen at 90%. Staff contacted the on-call physician’s number at 4:45 a.m. Vitals were repeated at 5:13 a.m. with blood pressure at 64/40, pulse at 143, temperature at 93.5, and oxygen at 64%. The note goes on to say that the on-call service called back and instructed staff to contact 911 and have Resident A sent in. No time was listed as to when on-call got back with staff. The note indicates that 911 was called and responded at approximately 5:38 a.m. and Resident A was transported to Spectrum Butterworth Hospital where she passed away soon after being transferred from the emergency dept. to the intensive care unit.

Based on Ms. Ayers’ explanation of the electronic charting system, one can conclude that since no additional ‘Interdisciplinary Notes’ were created during the evening of 01/07/2019 and the overnight of 01/08/2019, nothing out of the ordinary was observed by staff during their two hour checks.

On 01/29/2020, I interviewed by telephone FM#2. While FM#2 did not have any additional information to provide, FM#2 stated he supports FM#1 pursuing this investigation to ensure that Resident A received emergency medical care in a proper and timely manner.

On 02/03/2020, I interviewed by telephone Resident A’s physician who regularly saw Resident A at the facility, Dr. Neubig. Dr. Neubig stated that she had a conversation with FM#1 in December of 2018 regarding Resident A’s health concerns and broached the subject of enrolling Resident A in Hospice but the family was not interested in that. Dr. Neubig stated she also discussed hospitalizing Resident A with FM#1 after discussing the case with Resident A’s cardiologist but FM#1 did not want to risk unnecessary procedures being carried out with Resident A.
Dr. Neubig stated that during the early hours of 01/08/2019, Resident A’s lowered blood pressure could come from Resident A’s arrythmic heart disease. The PRN of Morphine taken the evening before could also have lowered Resident A’s blood pressure. Dr. Neubig pointed out that Resident A’s vascular disease could cause the pain to Resident A’s lower extremities which was eased by sitting Resident A in her chair, but this could also lower Resident A’s blood pressure. Dr. Neubig pointed out that she was not the doctor on-call but based on her knowledge of Resident A’s health, it appeared to her that the facility staff acted appropriately during the night of

01/08/2019. Dr. Neubig also pointed out that the facility staff would not have had the ability to test for or diagnose the septicemia that was subsequently identified by the emergency dept. at Spectrum Butterworth hospital.

On 02/07/2020, I interviewed by telephone staff Della Hunnicutt. Ms. Hunnicutt stated that she remembers Resident A in general but does not recall the evening of 01/07/2019, in particular. I tried to prompt Ms. Hunnicutt with the fact that Resident A seemed to be in discomfort during the evening of 01/07/2019 and received two PRN medications for pain. I reminded Ms. Hunnicutt that staff Melissa Melberg had been the medication passer for the 2nd shift but Ms. Hunnicutt stated she still could not recall the evening.

On 02/10/2020, I received a copy of the report completed by the Kentwood Fire Dept. (FD) for their response to the 911 call on 01/08/2019. The FD report indicated times for the call, response, and departure. According to the report, the FD arrived at the scene approximately one minute before the Life EMS Ambulance arrived at 5:37 a.m. The report states that they assisted the EMT's with loading Resident A for transport to the hospital. That is the extent of the report.

On 02/11/2020, I interviewed by telephone staff Hannah Smith. Ms. Smith stated that she recalled Resident A but does not recall anything specific from the night of 01/08/2019. Ms. Smith stated that neither she nor staff Aida Kubic would have taken Resident A's vitals during the 3rd shift pointing out that a 'team lead' would have been called in. Ms. Smith stated that on 01/08/2019, staff Rejema Griffin could have been the team lead that night. Ms. Smith stated the belief that Ms. Griffin would have been working in another building when I pointed out that Ms. Smith was working with staff Aida Kubic. Ms. Smith stated that whomever the team lead was, they would have been called over for assistance which would be the practice.

On 02/12/2020, I interviewed by telephone staff Aida Kubic. Ms. Kubic recalled Resident A very well and recalled the night of 01/08/2019. Ms. Kubic did not recall that Ms. Smith was working with her but does recall that staff Rejema Griffin was the team leader. Ms. Kubic stated that during the course of her checks every 2 hours, she observed that Resident A did not seem herself and her speech was difficult to understand. Ms. Kubic stated that she asked Resident A if she was in pain and Resident A said "yes." Ms. Kubic stated that she immediately got the team leader, Ms. Griffin, for assistance. Ms. Kubic stated that Ms. Griffin asked Resident A if she wanted to get out of bed to which Resident A replied, "yes" so they assisted her out of bed and sat Resident A in her recliner. Ms. Kubic stated that Ms. Griffin checked Resident A's blood sugar first and then took Resident A's vital signs. Ms. Kubic stated that she had worked with Resident A for many years so she recognized that something was wrong with Resident A. Ms. Kubic stated that she stayed seated next to Resident A, holding her hand while Ms. Griffin contacted the on-call doctor and then called 911 for an ambulance. Ms. Kubic stated she did not greet the ambulance when it arrived. Ms. Kubic stated the belief that Ms. Griffin greeted the ambulance as she herself, had to address duties with other residents. When asked

if she saw any facial “droop”, Ms. Kubic stated that she did not observe this. The only thing she noted with Resident A’s face was that Resident A was very pale and seemed to be having some difficulty talking. Ms. Kubic could not recall specific times as to when she first became concerned about Resident A, sought Ms. Griffin’s assistance, or when Ms. Griffin took Resident A’s vitals, contacted the on-call, or when Ms. Griffin contacted 911. Ms. Kubic described the situation as if it had all taken place quickly.

On 02/12/2020, I interviewed by telephone staff Rejema Griffin. Ms. Griffin recalled Resident A and the night of 01/08/2019. Ms. Griffin stated that Ms. Kubic had come to her saying that Resident A didn’t look right and was not breathing right but Ms. Griffin could not recall the specific time. Ms. Griffin stated that as the team lead, she checked Resident A’s blood sugar but it was within range so Ms. Griffin took Resident A’s vitals and contacted the on-call physician immediately for assistance because of the readings she was getting. Ms. Griffin stated that because a year has passed, she could not recall specifically the time(s) when she completed these activities. Ms. Griffin stated that the on-call physician said to her, “what are you doing on the phone, send her (Resident A) out.” Per policy, Ms. Griffin stated that she then called the DPOA who is FM#2 but was interrupted by Ms. Kubic who asked her to come to Resident A. Ms. Griffin stated that she immediately contacted 911 and met the ambulance when it arrived. Again, Ms. Griffin stated that because of the amount of time that has passed, she could not recall what time she called 911 or what time they arrived. Ms. Griffin stated that she was familiar with Resident A so she couldn’t explain why the ambulance driver had written in his report that the staff who met them said she didn’t know Resident A. Ms. Griffin stated that she was not typically assigned to the facility that Resident A lived in but as team lead, she was familiar with Resident A. Regarding the ‘drooping face’ mentioned by the ambulance driver, Ms. Griffin stated that it was not apparent to her or Ms. Kubic when Resident A was sitting in her chair because Resident A’s skin sagged. Ms. Griffin stated that she could see it when the EMT’s had put Resident A on the stretcher. Ms. Griffin stated she did not understand and could not explain the ambulance driver’s comments in his report.

On 02/19/2020, I reviewed by telephone the findings of my investigation with FM#1. FM#1 disagreed with these findings.

On 02/20/2020, I conducted by telephone an exit conference with the acting licensee designee, Nancy Ayers. Ms. Ayers concurred with the findings of my investigation.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.

ANALYSIS:	Staff Della Hunnicut stated she could not recall the evening of 01/07/2019 and staff Melissa Melberg passed away in 2019. Staff Hannah Smith stated she could not recall the night of 2019. Documentation in the Daily Charting system indicates that Ms. Hunnicutt and Ms. Melberg had checked Resident A every two hours without additional comment, which suggests that when Resident A received her second PRN that evening, it helped Resident A. The Daily Charting completed by staff Hannah Smith and Aida Kubic indicates that aside from the Interdisciplinary Note completed by staff Rejema Griffin, the two-hour checks on Resident A were not remarkable. Staff Aida Kubic and staff Rejema Griffin recalled the night of 01/08/2019 and described that Ms. Kubic observed Resident A in distress and obtained the assistance of Ms. Griffin since Ms. Griffin was the Team Lead. Each described what Ms. Griffin did to assess Resident A and the follow-up completed on Resident A's behalf. Neither Ms. Kubic nor Ms. Griffin could recall the specific times, however, since over a year has passed. The Interdisciplinary Note created by staff Rejema Griffin on 01/08/2019 was entered at 7:41 a.m., almost two hours after Resident A left the facility in the ambulance. This calls into question the first contact time listed as 4:00 a.m. as remembered by Ms. Griffin. The descriptions by Ms. Kubic and Ms. Griffin of what transpired suggest that the first identification of something wrong with Resident A could be later than 4:00 a.m. since Ms. Griffin documented the first vitals taken at 4:38 a.m. I do not find a preponderance of evidence to support that a rule violation has occurred.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: There is a question as to whether PRN medications for pain were documented in the medication record when passed to Resident A.

INVESTIGATION: On 12/05/2019, the Department received a complaint alleging that when Resident A received PRN medications for pain during the evening of 01/07/2019, this was not documented in the medication record.

On 12/12/2019, I interviewed FM#1 by telephone. FM#1 stated that when reviewing Resident A's chart over the telephone with Resident A's physician on 01/08/2019, there was no mention of the PRN's being documented on the electronic medication record.

On 01/17/2020, I reviewed materials from Resident A's file, in particular, the medication record from the evening of 01/07/2019. The medication record indicated that at 8:11 p.m., Resident A received a PRN of Norco and at 10:40 p.m., Resident A received a PRN of Morphine. The medication record indicated that staff Melissa Melberg passed both PRN medications.

On 01/29/2020, I reviewed by telephone with the administrator, Nancy Ayers, how the electronic record works. Ms. Ayers pointed out that staff have 24 hours to document in the medication record and the system will not let them add or delete anything after the 24-hour period. Ms. Ayers stated that the record is also date and time stamped in the computer when an entry is made.

On 02/19/2020, I reviewed the findings of my investigation with FM#1.

On 02/20/2020, I completed by telephone an exit conference with the acting licensee designee, Nancy Ayers. Ms. Ayers concurred with the findings of my investigation.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4)(b) Complete an individual medication log that contains all of the following information: **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	I reviewed Resident A's medication log and observed that Resident A received a PRN for pain at 8:11 p.m. and again at 10:40 p.m. The administrator, Nancy Ayers, stated that the electronic record can only be added to or modified within 24 hours.

	I do not find a preponderance of evidence to support that a rule violation has occurred.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: There is a question as to whether staff are properly trained.

INVESTIGATION: On 12/05/2019, the Dept. received a complaint suggesting that staff did not know how to properly assess Resident A's health condition during the night of 01/08/2019 and possibly during the previous evening of 01/07/2019. The complaint suggests that this lack of an appropriate response to Resident A's emergent health needs indicates a lack of training of the staff.

On 01/14/2020, I interviewed FM#1 off site. During this interview, FM#1 suggested that it appears that staff ignored Resident A's health crisis to the extent that they did not respond immediately to the situation and seek medical care for Resident A in a timely manner. FM#1questioned their training to work in the facility and wondered if the staff at the facility had CNA certifications. I pointed out that a CNA certification is not a requirement of Adult Foster Care Licensing.

On 01/17/2020, I met with the administrator, Nancy Ayers and discussed how staff are taught to take vitals. Staff, Tina Raimer, assisted in discussing the training on taking 'vitals'. Ms. Raimer stated that new staff shadow an experienced staff for 10 shifts before working independently. Ms. Raimer pointed out that if a new staff requests more time for training or if the experienced staff suggests that the new staff would benefit from more training, then more shadow shifts would occur. Ms. Raimer stated that new staff would have to demonstrate competency before being allowed to work independently. When asked how staff know what to do with the information obtained from taking a resident's vitals if the resident is in crisis, for example, she pointed out that the machine used for taking vitals has an alarm which would sound and the computer program used by the licensee also would alert the staff if the vitals taken were not in a safe range when the staff enters the information on the resident's chart. Ms. Raimer also pointed out that staff have to be "checked off as competent" on taking a resident's blood pressure manually, as well, before working independently.

On 01/17/2020, I interviewed by telephone FM#1. FM#1 expressed concern during this conversation and in previous contacts that a lack of training caused staff to not recognize what vital signs taken prior to sending Resident A to the hospital meant so Resident A could have been sent in sooner than what occurred.

On 01/31/2020, I reviewed staff personnel files for, Melissa Melberg and Della Hunnicutt (the two staff working the evening of 01/07/2019), the files for the 3rd shift staff who worked on 01/08/2019 (Hannah Smith and Aida Kudic), and the file of the staff who worked as team lead in the early hours of 01/08/2020 (Rejema Griffin).

The human resource person for the licensee, Samantha Bull, assisted me in my review of the files. This review occurred at the Clark Home main offices.

Ms. Bull pointed out that in addition to the required trainings for Adult Foster Care Licensing necessary before a staff works independently, staff have to retake/update their training in the competency areas on an annual basis. The competency check list includes resident vitals. Ms. Bull stated that none of the five staff reviewed have a CNA certificate which is not a requirement for Adult Foster Care Licensing.

I observed the following in the staff files:

1. Hannah Smith was hired on 08/01/2018. There was documentation that Ms. Smith had all of the required trainings and documentation of the annual training in the competency areas.
2. Melissa Melberg was hired on 10/29/2003. There was documentation that Ms. Melberg had all of the required trainings and documentation of the annual training in the competency areas. It should be noted that Ms. Melberg passed away during 2019.
3. Della Hunnicutt was hired on 08/04/2008. There was documentation that Ms. Hunnicutt had all of the required trainings and documentation of the annual training in the competency areas.
4. Aida Kudic was hired on 07/07/2008. There was documentation that Ms. Kudic had all of the required trainings and documentation of the annual training in the competency areas.
5. Rejema Griffin was re-hired on 09/26/2018 after having left the licensee for a period of time. There was documentation that Ms. Griffin had all of the required trainings and documentation of the annual training in the competency areas.

On 02/19/2020, I reviewed by telephone the findings of my investigation with FM#1.

On 02/20/2020, I conducted by telephone an exit conference with the acting licensee designee, Nancy Ayers. Ms. Ayers concurred with the findings of my investigation.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before

	performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	I reviewed the personnel files for each of the 5 staff working at the facility on 01/07/2019 and 01/08/2019. I observed documentation that each was trained per AFC Licensing rules and each was trained in the competency areas required by the licensee on an annual basis. I do not find a preponderance of evidence to support that a rule violation has occurred.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING: The reasons for passing a PRN to Resident A were not documented in the medication administration record (MAR).

INVESTIGATION: On 01/14/2020, during a face to face contact with FM#1, FM#1 expressed concern that when Resident A received PRN's for pain on 01/07/2019, the reasons for passing the PRN's were not documented in the MAR.

On 01/17/2020, I was given pages of documentation of medications administered for the month of January 2019 during my on-site review. The reason for giving the PRN was on a separate document from the daily MAR which I missed in my initial review. Resident A received a PRN for pain as follows;

- On 01/02/2019 at 4:45 p.m., Resident A was moaning in pain.
- On 01/02/2019 at 8:26 p.m., no reason was given but the PRN was noted as "effective."
- On 01/05/2019 at 10:11 p.m., Resident A complained of leg pain.
- On 01/05/2019 at 12:35 a.m., no reason was given but it was noted that Resident A had "settled down and was sleeping."
- On 01/07/2019 at 5:18 a.m., Resident A was complaining of leg pain.
- On 01/07/2019 at 8:11 p.m., Resident A was given the PRN for pain.
- On 01/07/2019 at 10:40 p.m., Resident A complained of still being in pain.

From this review, I conclude that there were two instances in the month of January 2019 in which staff did not write a reason for administering the PRN for pain.

On 01/19/2020, the issue of why Resident A was given PRN's for pain was again brought up by FM#1.

On 02/20/2020, I completed by telephone an exit conference with the acting licensee designee, Nancy Ayers. Ms. Ayers accepted the findings of my investigation and had no additional comments for my report.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (c) Record the reason for each administration of medication that is prescribed on an as needed basis.
ANALYSIS:	I reviewed the medication administration record for Resident A and observed that in two instances in January of 2019, staff did not record a reason for the administration of a PRN for pain.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend that the status of the license remain unchanged.

01/21/2020

Grant Sutton Date
Licensing Consultant

Approved By:

01/21/2020

Jerry Hendrick Date
Area Manager